CASE REPORTS

Aureomycin in the Treatment of Herpes Zoster

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AUREOMYCIN has been used for a wide spectrum of diseases, but so far as is known, no report has been published of use of the drug in the treatment of herpes zoster. This is the report of a case of that disease in which aureomycin was given with gratifying results.

CASE REPORT

A 55-year-old white female, when first examined on January 3, 1949, had a typical herpetic lesion involving the left face, extending from the lateral border of the mandible to the mid-line of the nose, and from the mid-forehead to the lateral border of the mouth. In the next three days, the patient was given large doses of vitamin B complex, codeine for relief of pain, and twice was vaccinated with smallpox vaccine. The lesion became more severe, with intense burning, and pronounced edema completely closed the left eye. There was evidence of beginning conjunctival ulceration.

On the fourth day, as a measure of desperation, aureomycin was given, 250 gm. every three hours day and night. Within 24 hours subjective and objective improvement was noted. Codeine was stopped and the patient was able to open the left eye to some extent. Forty-eight hours after treatment with aureomycin was started, the conjunctiva had practically cleared, the rash was much improved, and there was very little residual swelling. The dosage was reduced to 250 mg. four times a day and maintained at that level for three more days. By the end of this time the patient was experiencing no symptoms aside from a very mild burning sensation, and the rash had almost completely disappeared. There was no edema. Treatment with aureomycin was discontinued, and vitamin B complex therapy resumed. All signs and symptoms had disappeared by February 2, 1949, with the exception of a slight burning sensation in the region of the temporomandibular joint and slight erythema over the involved area. Later, even these symptoms completely disappeared.

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Extraocular Muscle Paralysis from Spinal Injection of Pantopaque

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PARALYSIS of extraocular muscles occurs in many conditions. It is caused principally by impaired blood supply to the nerves or to their nuclei, or by direct damage to the nerve cells by a toxic agent. Many conditions have been implicated as precipitating factors. Among them are spinal anesthesia,[4, 5, 6] general anesthesia,[2] trauma,[1] otogenic disease, intraorbital inflammations, syphilis, multiple sclerosis, meningitis, encephalitis, nephritis, diabetes, neoplasms,[9] and poliomyelitis.[12]

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The sixth cranial nerves are peculiarly liable to damage in intracranial disturbances, owing to the sharp bend they take over the border of the petrous ridge, and because the antero-inferior cerebellar and internal auditory arteries cross the nerves at right angles and often lie ventral to them. Parsons[8] expressed the belief this might account for cases of external rectus palsy following spinal anesthesia. Peter[9] mentioned a case in which abducens paralysis appeared in a baby soon after withdrawal of spinal fluid.

Levine,[6] in a review of extraocular muscle palsy occurring after spinal anesthesia, quoted Blanluet and Caron as believing that the palsy was caused by elective toxic action, localized hemorrhage, or mild meningeal infection; Bonnier as believing that the palsy was a reflex from the injected anesthetic fluid reaching the labyrinth and exciting irritation there; Holmes as believing that localized collections of fluid compressed the nerves themselves; and Schmidt-Rimpler as believing that the sixth nerves are most often affected because of their superficial position in relation to the fourth ventricle, the latter communicating through the foramen of Magendie and lateral apertures with the arachnoid space of the cord which carries the anesthetic fluid.

Myelography as a cause of extraocular muscle paralysis is not mentioned in the literature. Use of this procedure with Pantopaque for diagnostic purposes is rather common, especially in diagnosis and localization of injury to intervertebral discs. Pantopaque is a mixture of ethyl esters of isomeric iodophenylundecylic acids in absorbable oil type media of relatively low viscosity. Since it is absorbable, any small residue after its use is said to be readily eliminated.[11]

Ramsey and Strain[11] observed few reactions from use of the material, those being mild aseptic meningeal reaction or transient muscle aching, headache, paresthesia of the lower extremities, or possibly temperature elevation. They stated no complications as a result of Pantopaque myelography had been observed. Copleman[3] noted no reactions resulting from retention of the material in the subarachnoid space in cases in which complete removal had not been possible. Preacher and Robertson[10] observed one case in which there was benign meningeal reaction following intracranial progression of Pantopaque. Wyatt and Spurling[13] observed no toxic reactions following use of the material. Lindblom,[7] in a summary of complications following myelography with the use of Abrodil or Skiodan (an iodized oil), mentioned no cases of extraocular muscle palsy, though headache, stiff neck, hyperesthesia and shock were fairly common (54 complications in 721 cases). However, Lindblom used novocain spinal anesthesia before introducing the radiopaque oil into the spinal canal.

The following case shows that Pantopaque myelography may be attended by unexpected consequences:

CASE REPORT

A white male patient 37 years of age was treated conservatively throughout 1946 for pain in the left sacro-iliac area and down the left thigh. In August 1947, a myelographic examination was made at a Veterans Administration hospital. Pantopaque was used and 8 to 10 cc. of spinal fluid was withdrawn. Occipital headache and pain in the

back of the neck, which the patient described as "severe," developed. The patient was discharged from the hospital as improved, although no treatment had been given; the pain in the lower back was considered not due to organic disease.

Five days after the myelographic examination, the patient became aware of diplopia and he became dizzy and nauseated. Examination of the eyes showed normal acuity of vision in both. A cover test showed esotropia of 8 diopters at 6 meters and exophoria of 4 diopters at 33 centimeters. A motility test showed the external rectus muscle of the right eye to be paretic. The fundi were normal. A patch was worn over the right eye for two weeks and at the end of that time the acuity of the right eye was 20/25; of the left, 20/25. There was esotropia of 15 diopters at 6 meters and right hypertropia of 4 diopters at the same distance. Three months after onset, diplopia suddenly ceased, and two weeks later all evidence of extraocular muscle weakness disappeared. At that time there was again normal acuity of vision in both eyes, and a cover test showed orthophoria at 6 meters. At 33 centimeters there was exophoria of 6 diopters. Motility was normal. The near point of convergence was at 100 mm.

COMMENT

The symptoms in this case remarkably resembled those of abducens paralysis following spinal anesthesia. The delayed onset, spontaneous recovery and solitary abducens palsy were typical of the circumstances reported for that condition.

SUMMARY

A case of extraocular muscle paralysis following myelography with Pantopaque is reported. Spontaneous recovery occurred with conservative treatment.

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Foreign Bodies in the Rectum Simulating Anorectal Disease

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THE classical symptoms of anorectal disease such as pain, pressure, protrusion, bleeding, and alteration of bowel habit are familiar to all physicians.

These symptoms may also be produced by foreign bodies lodged within the terminal portion of the alimentary canal, thus simulating anorectal disorders more commonly encountered in proctologic practice. According to Bacon[1] there are four routes by which a foreign body may enter the rectum. These are: By ingestion and normal passage to its terminus; through development within the intestinal tract; by entry from a neighboring organ; and finally by insertion through the anus. Obviously, entry through either the upper or lower orifice of the alimentary tract is the most common. Many bizarre foreign bodies have been reported in the literature[2] and it is not necessary to detail them here.

The following case reports are offered to illustrate the mimicry of anorectal disease by the presence of these objects, to demonstrate the advisability of considering foreign body in the evaluation of proctologic complaints, and lastly to show how readily diagnosis may be made if the patient is examined and not merely given a suppository and a word of reassurance. The presence of a foreign body was suspected in only one of the four cases—Case 4—and then only because of the patient's manner while giving the history.

CASE REPORTS

Case 1: A 75-year-old white man entered the office complaining of severe anal pain of sharp character aggravated by stool and following stool for the preceding four days. An occasional streak of blood had been noted on the toilet tissue. Inspection of the anal area disclosed no abnormality. The sphincter was tightly contracted. Upon digital examination a sharp, hard object lodged just above the internal sphincter was noted. This was extracted and proved to be a fragment of bone an inch long and one-half inch wide. The patient, who wore dentures, surmised that it had been ingested with lamb stew eaten several days previously. Proctoscopic findings were normal.

Case 2: A 63-year-old white man reported with the complaint of painful protrusion from the anus of two days' duration which had appeared suddenly after stool and could not be reduced. Usual palliative remedies had afforded no relief. Inspection of the anus revealed a spicule of bone protruding from the orifice. The fragment was removed and found to be a thin lance-shaped bone measuring 1¼ by ½ inches. The patient, who wore dentures, said that he probably had swallowed the bone while eating ground chicken several days previously. Proctoscopic findings were normal.

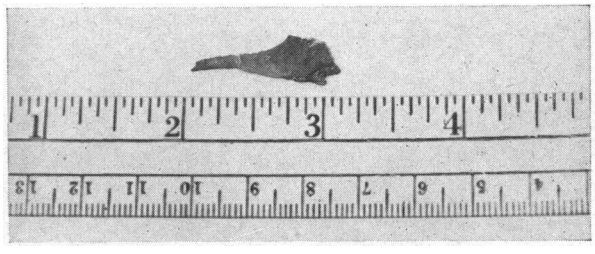

Figure 1.—Chicken bone fragment removed from the anus that caused severe pain and bleeding.